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CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

# ASSEMBLY BILL No. 1203

**Introduced by Assembly Member Salas**

February 23, 2007

An act to amend Sections ~~1317.1 and 1371.4~~ *1317.1, 1371.4, and 1386* of, and to repeal and add Section 1262.8 of, the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1203, as amended, Salas. Health care service plans: noncontracting hospitals: poststabilization care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the licensure and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a misdemeanor.

Existing law provides that for purposes of specified provisions governing the stabilization of patient care, a patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient, as provided.

This bill would also provide that, for purposes of these provisions a patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, no such material deterioration of the patient's condition is likely to result from, or occur during, the release of the patient, as provided.

Existing law requires a noncontracting hospital to contact an enrollee's health care service plan to obtain the enrollee's medical record information prior to admitting the enrollee as an inpatient for poststabilization care, transferring an enrollee to a noncontracting hospital for poststabilization care, or providing poststabilization care to an enrollee admitted for medically necessary care, under specified conditions. Existing law requires a health care service plan contacted by a hospital under these circumstances to, among other things, discuss the enrollee's medical record with an appropriate hospital representative and transmit any appropriate and requested portion of the enrollee's medical record to the hospital representative. Existing law requires a health care service plan, or its contracting medical providers, to provide 24-hour access for providers to obtain timely authorization for medically necessary care in specified circumstances. Existing law also prohibits a noncontracting hospital that is required to contact an enrollee's health care service plan, and fails to do so, from billing the enrollee for poststabilization care.

This bill would recast those provisions to ~~prohibit a noncontracting hospital from providing poststabilization care to a patient who is an enrollee of a health care service plan that requires prior authorization for poststabilization care unless specified requirements are met~~ *provide that if a patient with an emergency medical condition, as defined, is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital, except as provided, shall, once the emergency medical condition has been stabilized, but prior to providing poststabilization care, retrieve information from the patient and the patient's health care service plan or the health plan's contracting medical provider, and provide information to the plan or provider about the patient, as specified*. The bill would provide that

certain provisions governing poststabilization care shall not apply to minor treatment procedures if specified conditions apply. The bill would prohibit a noncontracting hospital from billing that patient for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless the patient assumes financial responsibility for the care, as specified, or the hospital is unable to obtain the health care service plan's name and contact information, as specified. The bill would delete the requirement that a health care service plan contacted for poststabilization care authorization discuss the enrollee's medical record with an appropriate hospital representative and would, instead, ~~require the noncontracting hospital's representative, upon receiving authorization for poststabilization care, to~~ *provide that if poststabilization care has been authorized by the health care service plan, that the noncontracting hospital* request the patient's medical record from the patient's plan or its contracting medical provider. In addition, the bill would specifically require that a health care service plan, or its contracting medical providers, provide 24-hour access for noncontracting hospitals to obtain timely authorization for poststabilization care, as specified. The bill would enact other related provisions.

*Existing law authorizes the Director of the Department of Managed Health Care, after notice and opportunity for a hearing, to suspend or revoke a license or assess administrative penalties if the director determines that the licensee committed an act or omission constituting grounds for disciplinary action, as specified.*

*This bill would add a plan that violates the above provisions relating to poststabilization care to the list of acts or omissions that constitute grounds for disciplinary action.*

Because a violation of the bill's provisions would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

SECTION 1. Section 1262.8 of the Health and Safety Code is repealed.

SEC. 2. Section 1262.8 is added to the Health and Safety Code, to read:

1262.8. (a) A noncontracting hospital shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless ~~the requirements of subdivision (f) are met or the~~ *one of the following conditions are met:*

*(1) The patient or the patient's spouse or legal guardian refuses to consent, pursuant to subdivision (f), for the patient to be transferred to the contracting hospital as requested and arranged for by the patient's health care service plan.*

*(2) The* hospital is unable to obtain the name and contact information of the patient's health care service plan as provided in subdivision (c).

~~(b) If a patient with an emergency medical condition is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital shall not provide poststabilization care, except as provided in subdivision (n), to the patient unless both of the following conditions are met:~~

~~(1) The hospital does all of the following once the emergency medical condition has been stabilized:~~

*(b) If a patient with an emergency medical condition, as defined by Section 1317.1, is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital, except as provided in subdivision (n), shall, prior to providing poststabilization care, do all of the following once the emergency medical condition has been stabilized, as defined by Section 1317.1:*

~~(A) Seeks~~

*(1) Seek* to obtain~~, exercising reasonable diligence,~~ the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information ~~in the patient's medical record. For purposes of this subparagraph, "reasonable diligence" means requesting the patient's health care service plan member card or asking the patient, or a family member~~

~~or friend accompanying the patient, if he or she can identify the patient's health care service plan.~~

~~(B) Contacts the patient's health care service plan, or its~~ *in the patient's medical record, which shall include requesting the patient's health care service plan member card or asking the patient, or a family member or other person accompanying the patient, if he or she can identify the patient's health care service plan, or any other means known to the hospital for accurately identifying the patient's health care service plan.*

*(2) Contact the patient's health care service plan, or the health plan's* contracting medical provider, for authorization to provide poststabilization care, if identification of the plan was obtained pursuant to ~~subparagraph (A)~~ *paragraph (1)*.

~~(i)~~

*(A)* The hospital shall make the contact described in this subparagraph by either following the instructions on the patient's health care service plan member card or using the contact information provided by the patient's health care service plan pursuant to subdivision (j) or (k).

~~(ii)~~

*(B)* A representative of the hospital shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the hospital upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.

~~(C)~~

*(3)* Upon request of the patient's health care service plan, or ~~its~~ *the health plan's* contracting medical provider, ~~provides~~ *provide* to the plan, or its contracting medical provider, the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary *for the health care service plan or the plan's contracting medical provider* to make a decision to authorize poststabilization care or to assume management of the patient's care by prompt transfer.

~~(2) One of the following conditions applies:~~

~~(A) The patient's health care service plan, or its contracting medical provider, provides authorization for the poststabilization care.~~

~~(B) The patient's health care service plan, or its contracting medical provider, fails to respond to the hospital's contact pursuant to subparagraph (B) of paragraph (1) within the period of time described in subdivision (d).~~

~~(C) The patient's health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer and either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time or the patient, or his or her representative, does not consent to the transfer pursuant to subdivision (e).~~

(c) A noncontracting hospital that is not able to obtain the name and contact information of the patient's health care service plan pursuant to subdivision (b) is not subject to the requirements of this section.

(d) (1) A health care service plan, or its contracting medical provider, that is contacted by a noncontracting hospital pursuant to ~~subparagraph (B) of paragraph (1)~~ *paragraph (2)* of subdivision (b), shall, within 30 minutes from the time the noncontracting hospital makes the initial contact, do either of the following:

(A) Authorize poststabilization care.

(B) Inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) If the health care service plan, or its contracting medical provider, does not notify the noncontracting hospital of its decision pursuant to paragraph (1) within 30 ~~minutes, or fails to transfer the patient within a reasonable time~~ *minutes*, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay reasonable charges for the care in compliance with Section 1371.

*(3) If the health care service plan, or its contracting medical provider, notified the noncontracting hospital that it would assume management of the patient's care by prompt transfer, but either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges, in accordance with the Knox-Keene Health Care Service*

*Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder, for the care until the enrollee is transferred.*

*(4) If the health care service plan, or its contracting medical provider, provides authorization to the noncontracting hospital for specified poststabilization care and services, the health care service plan, or its contracting medical provider, shall be responsible to pay for that authorized care.*

(e) If a health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer, the health care service plan, or its contracting medical provider, shall do all of the following:

(1) Arrange and pay the reasonable charges associated with the transfer of the patient.

(2) Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability.

(3) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer of the patient.

(f) (1) If the patient, or the patient's spouse or legal ~~guardian, does not~~ *guardian refuses to* consent to the patient's transfer under subdivision (e), ~~the health care service plan, or its contracting medical provider~~ *the noncontracting hospital*, shall promptly provide a written notice to the ~~noncontracting hospital~~ *patient or the patient's spouse or legal guardian* indicating that the patient will be financially responsible for any further poststabilization care provided by the hospital.

*(2) For patients whose primary language is one of the Medi-Cal threshold languages, the notice shall be delivered to them in their primary language.*

*(3) The Department of Managed Health Care shall translate the notice required by this subdivision in all Medi-Cal threshold languages and make the translations available to the hospitals subject to this section.*

~~(2)~~

*(4)* The written notice provided pursuant to this subdivision shall include the following statement:

~~"You have just received emergency care at a hospital that is not in your health plan's network. Your health plan pays for emergency care.~~

~~The doctor who is taking care of you at this hospital has decided that your health is stable and you may be safely moved to another hospital that is covered by your health plan for more care.~~

~~If you agree to be moved to a hospital that is covered by your health plan, the plan will pay for the transportation and your care at that in-network hospital. You will only have to pay for your deductible, copayments, or co-insurance.~~

~~IF YOU DECIDE TO STAY AT THIS HOSPITAL, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOUR HEALTH IS STABLE. This cost includes the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive after this point.~~

~~IF YOU DO NOT THINK YOU CAN BE SAFELY MOVED, TALK TO THE DOCTOR ABOUT YOUR CONCERNS. YOU MAY ALSO CALL YOUR HEALTH PLAN MEMBER SERVICES DEPARTMENT FOR HELP. LOOK ON YOUR HEALTH PLAN MEMBER CARD FOR THAT NUMBER. YOU MAY ALSO CALL THE HMO HELPLINE, 24 HOURS A DAY, 7 DAYS A WEEK, AT 888-HMO-2219."~~

~~(3) The health care service plan, or its contracting medical provider, shall provide two copies of the written notice required by this subdivision to the hospital. The health care service plan, or its contracting medical provider, may send these copies to the hospital by facsimile. The hospital shall give one copy to the patient, or the patient's spouse or legal guardian, for signature and may retain the other copy.~~

*THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW*

*"You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided*

*that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.*

*If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, copayments, or coinsurance for care. You will not have to pay for your deductible, copayments, or coinsurance for transportation costs to another hospital that is covered by your health plan.*

*IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE. This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive.*

*If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:*

*Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.*

*The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay.*"

*(5) The hospital shall give one copy of the written notice required by this subdivision to the patient, or the patient's spouse or legal guardian, for signature and may retain a copy in the patient's medical record.*

~~(4)~~

*(6)* The hospital shall ~~cooperate in assuring~~ *ensure* prompt delivery of the notice to the patient or his or her spouse or legal guardian. The hospital shall obtain signed acceptance of the written notice required by this subdivision, and signed acceptance of any other documents the hospital requires for any further poststabilization care, from the patient or the patient's spouse or legal guardian, and shall provide the health care service plan, or its contracting medical provider, with confirmation of the patient's,

or his or her spouse or legal guardian's, receipt of the written notice.

~~(5) If a health care service plan, or its contracting medical provider, fails to provide the written notice required by this subdivision to the noncontracting hospital, the health care service plan, or its contracting medical provider, shall pay all reasonable charges for the poststabilization care provided to the patient.~~

~~(6)~~

*(7)* If the noncontracting hospital fails to meet the requirements of this subdivision, the hospital shall not bill the patient or the patient's health care service plan, or its contracting medical provider, for poststabilization care provided to the patient.

~~(g) Upon receiving authorization for poststabilization care, the noncontracting hospital's representative or the noncontracting physician and surgeon shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.~~

*(8) If the patient, or the patient's spouse or legal guardian, refuses to sign the notice, the noncontracting hospital shall document in the patient's medical record that the notice was provided and signature was refused. Upon the patient's refusal to sign, the patient shall assume financial responsibility for any further poststabilization care provided by the hospital.*

*(9) The Department of Managed Health Care may, by regulation, modify the wording of the notice required under this subdivision for clarity, readability, and accuracy of the information provided.*

*(10) The Department of Managed Health Care may, in conjunction with consumer groups, health care service plans, and hospitals, modify the wording of the notice to include language regarding Medicare beneficiaries, if appropriate under Medicare rules. The initial modification shall not be subject to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340, et. seq.) of Part 1 of Division 3 of Title 2 of the Government Code).*

*(g) If poststabilization care has been authorized by the health care service plan, the noncontracting hospital shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.*

(h) The health care service plan, or its contracting medical ~~provider, shall transmit any appropriate portion of the patient's medical record, if available, via facsimile transmission or electronic~~ *provider, shall, upon conferring with the noncontracting hospital, transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession, via facsimile transmission or electronic* mail, whichever method is requested by the noncontracting hospital's representative or the noncontracting physician and surgeon. The health care service plan, or its contracting medical provider, shall transmit the patient's medical record in a manner that complies with all legal requirements to protect the patient's privacy.

(i) A health care service plan, or its contracting medical provider, that requires prior authorization for poststabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary poststabilization care.

(j) A health care service plan shall provide all noncontracting hospitals in the state with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.

(k) In addition to meeting the requirements of subdivision (j), a health care service plan shall provide the contact information described in subdivision (j) to the ~~State Department of Public Health or the~~ Department of Managed Health Care. The contact information provided pursuant to this subdivision shall be updated as necessary, but no less than once a year. The receiving department shall post this contact information on its Internet Web site *no later than January 1 of each calendar year*.

(*l*) This section shall only apply to a noncontracting hospital.

(m) For purposes of this section, the following definitions shall apply:

~~(1) "Health care service plan" has the same meaning as that term is defined in Section 1345 and includes, but is not limited to, a Medi-Cal managed care plan.~~

*(1) "Health care service plan" means a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 that covers hospital, medical, or surgical expenses.*

(2) "Noncontracting hospital" means a general acute care hospital, as defined in subdivision (a) of Section ~~1250,~~ *1250 or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250,* that does not have a written contract with the patient's health care service plan to provide ~~poststabilization care~~ *health care services* to the patient.

(3) "Poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized, as defined by subdivision (j) of Section 1317.1.

*(4) "Contracting medical provider" means a medical group, independent practice association, or any other similar organization that, pursuant to a signed written contract, has agreed to accept responsibility for provision or reimbursement of a noncontracting hospital for emergency and poststabilization services provided to a health plan's enrollees.*

(n) Subdivisions (b) to (h), inclusive, shall not apply to minor treatment procedures, if all of the following apply:

(1) The procedure is provided in the treatment area of the emergency department.

(2) The procedure concludes the treatment of the presenting emergency medical condition of a patient and is related to that condition, even though the treatment may not resolve the underlying medical condition.

(3) The procedure is performed according to accepted standards of practice.

(4) The procedure would result in the direct discharge or release of the patient from the emergency department following this care.

*(o) Nothing in this section is intended to prevent a health care service plan or its contracting medical provider from assuming management of the patient's care at any time after the initial provision of poststabilization care by the noncontracting hospital before the patient has been discharged. Upon the request of the health care service plan or its contracting medical provider, the noncontracting hospital shall provide the health care service plan or its contracting medical provider with any information specified in paragraph (3) of subdivision (b).*

*(p) Nothing in this section shall authorize a provider of health care services to bill a Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan or otherwise alter the provisions of subdivision (a) of Section 14019.3 of the Welfare and Institutions Code.*

SEC. 3. Section 1317.1 of the Health and Safety Code, as amended by Section 1 of Chapter 544 of the Statutes of 1999, is amended to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) For the purposes of Section 1371.4, emergency services and care as defined in this paragraph shall not apply to services provided under managed care contracts with the Medi-Cal program to the extent that those services are excluded from coverage under the contract.

(C) This paragraph does not expand, restrict, or otherwise affect, the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Health Services.

(f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery.

(g) "Board" means the Medical Board of California.

(h) "Within the capability of the facility" means those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and specialty physicians, includes review of the patient's medical record, examination, and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

SEC. 4. Section 1371.4 of the Health and Safety Code is amended to read:

1371.4. (a) A health care service ~~plan,~~ *plan that covers hospital, medical, or surgical expenses,* or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the

enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further

necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j) (1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide poststabilization care.

(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding

whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.

(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(5) For purposes of this section, "poststabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.

*SEC. 5. Section 1386 of the Health and Safety Code is amended to read:*

1386. (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services that do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(7) The plan has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(8) The plan has permitted, or aided or abetted any violation by an employee or contractor who is a holder of any certificate, license, permit, registration, or exemption issued pursuant to the Business and Professions Code or this code that would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.

(9) The plan has aided or abetted or permitted the commission of any illegal act.

(10) The engagement of a person as an officer, director, employee, associate, or provider of the plan contrary to the provisions of an order issued by the director pursuant to subdivision (c) of this section or subdivision (d) of Section 1388.

(11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the director pursuant to Section 1388.

(12) The plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a

subsequent order under the provisions of Section 1203.4 of the Penal Code.

(13) The plan violates Section 510, 2056, or 2056.1 of the Business and Professions Code or Section 1375.7 ~~of the Health and Safety Code~~.

(14) The plan has been subject to a final disciplinary action taken by this state, another state, an agency of the federal government, or another country for any act or omission that would constitute a violation of this chapter.

(15) The plan violates the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(16) The plan violates Section 806 of the Military and Veterans Code.

*(17) The plan violates Section 1262.8.*

(c) (1) The director may prohibit any person from serving as an officer, director, employee, associate, or provider of any plan or solicitor firm, or of any management company of any plan, or as a solicitor, if either of the following applies:

(A) The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

~~SEC. 5.~~

*SEC. 6.* No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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